MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8473

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital #2 St. ..... Ward)

File No. ..... Registered No. 2139

2. FULL NAME Estelle C. Tyler

(a) Residence. No. 4179 W. Belle St., 11 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 3, 1875

7. AGE: Years 53 | Months 2 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St. Louis Mo

PARENTS

10. NAME OF FATHER: Geo. H. Tyler

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

12. MAIDEN NAME OF MOTHER: Margaret Howard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: Anna F. Woodard (Address) City Hospital #2

15. FILED FEB 15 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-13- 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-6- 1929, to 2-13- 1929, that I last saw her alive on 2-13- 1929, and that death occurred, on the date stated above, at 11:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis 23A

131 (duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) Chr. Nephritis

(duration) 9 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X ray

(Signed) T. E. Cunningham, M. D

, 19 (Address) 2945 Lawton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calavry

DATE OF BURIAL: 2/16 1929

20. UNDERTAKER: C. W. Roberts

ADDRESS: 3035 Lucas

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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